2010 Military Health System Conference

The Current and Future Prospective Payment System; Paying for Readiness-Type Costs

Sharing Knowledge: Achieving Breakthrough Performance

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OSD(HA), Health Budgets and Financial Policy

Resourcing the Direct Care System for Value

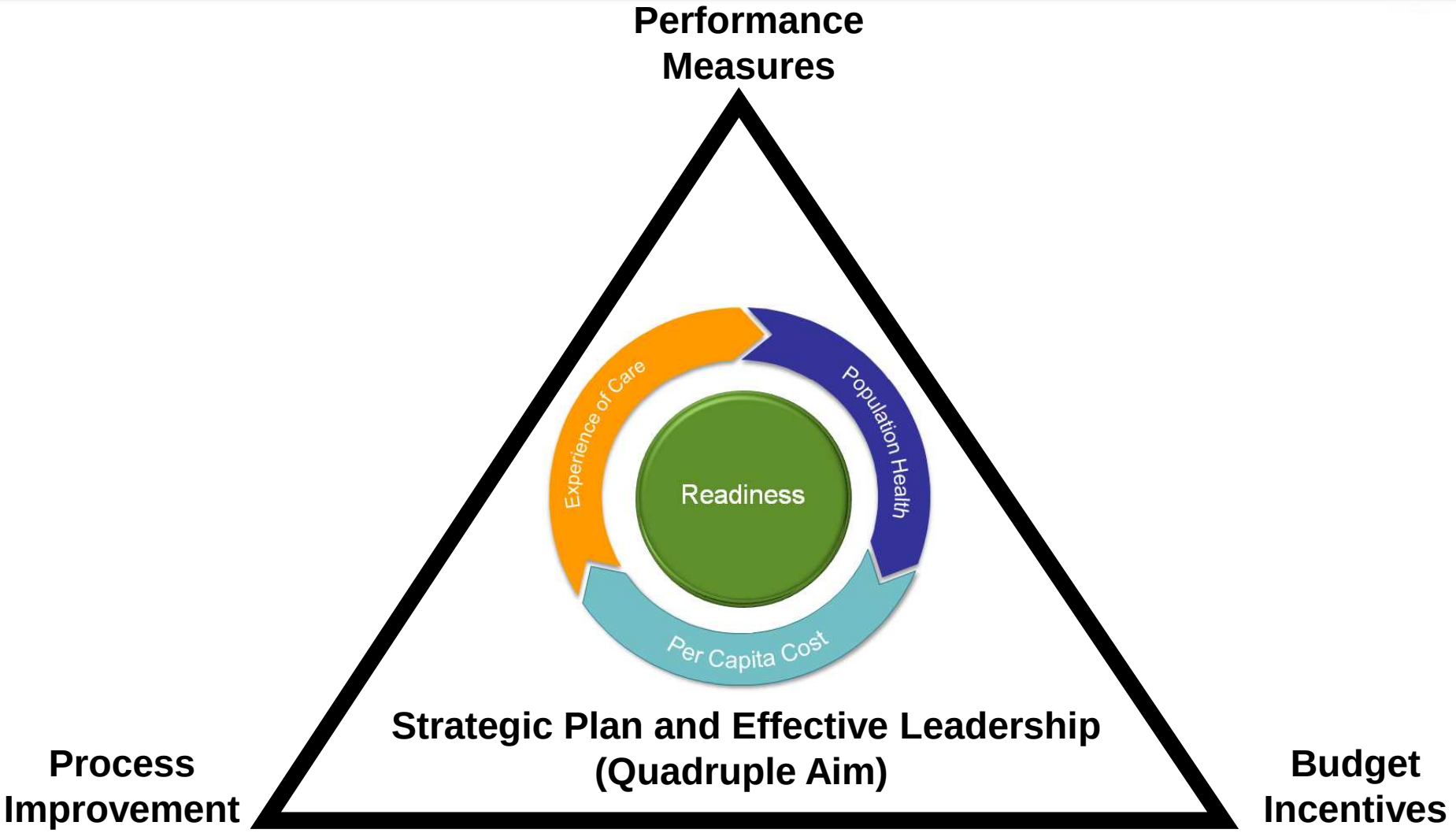
The Direct Care System (DCS) is the heart of military medicine and provides:

- a ready to deploy medical capability
- a medically ready force
- delivery of the health benefit to warriors and their families

..but at the appropriate value?

$$\frac{\text{Outputs (Activities)} + \text{Outcomes (Readiness, Population Health)} + \text{Customer satisfaction}}{\text{Resources (MilPers, appropriations, reimbursements)}}$$

Creating Breakthrough Performance in the MHS



Each Element is essential.

The Current Prospective Payment System

Mr. Greg Atkinson

Current PPS Section Agenda

- Current PPS Production and Valuation
- Changes to PPS workload reporting
- PPS workload values
- Rebaselining, Programmatic Changes, and Workload Commitment
- Budget Adjustment and Prior Mid-year Performance Adjustments

Current PPS Workload

- Inpatient – MEPRS A Workcenters
  - Non-Mental Health – Severity Adjusted DRGs Relative Weighted Products (RWPs)
  - Mental Health - Bed Days
- Outpatient – MEPRS B Workcenters
  - Enhanced Work + Practice Relative Value Units (RVUs)
    - Excluding Generic Providers and Nurses
  - Ambulatory Payment Classification (APCs)
    - Facility charges now available for Emergency Room (ER) and Same Day Surgery (SDS)
    - Consistent with TRICARE change for CY09

PPS Value of Care

- Value of MTF Workload
  - Fee for Service rate for workload produced
- Rates based on price at which care can be purchased
  - TMAC rates
  - Not MTF costs
- Computed at MTF level but allocated to services
  - Rolled up to Services

TMAC versus PPS

Civilian

- Inpatient
  - Institutional
    - Hospital (MS-DRG)
      - Including ancillaries, pharmacy
  - Professional (RVU)
    - Surgeon
    - Anesthesiologist
    - Rounds
    - Consultants
- Outpatient
  - Professional (RVU)
  - Institutional (APC)
- Outpatient Ancillary
  - (RVU/Fee Schedule)

Direct Care PPS

- Inpatient (RWP, i.e. MS-DRG)
  - All Institutional and Professional
    - Hospital
      - Including ancillaries, pharmacy
    - Surgeon
    - Anesthesiologist
    - Internist
    - Consultants
- Outpatient
  - Professional (RVU)
  - Institutional (APC)
    - Emergency Room and Same Day Surgery
- Outpatient Ancillary (Pass Thru)
  - None

Workload Measure Changes to PPS for FY10

- Move to MS-DRG from DRG
- Change from Simple Work RVU only to Enhanced Work + Non-Facility Practice RVU
- Addition of APCs for facility

DRG Comparison

- Historical DRG
  - System to classify hospital cases into one of approximately 500 groups
  - System in use since approximately 1983, with minor updates on a yearly basis
  - Calculated for TRICARE using CMS method just for our beneficiaries with-in Purchased Care claims
- MS-DRG – Severity Adjusted DRGs
  - System used to differentiate levels of complexity for the DRGs
  - Approximately 750 different groups
  - CMS implemented in 2008
  - TRICARE implemented in 2009

Impact of moving to MS-DRG

- Comparison of Rolling 12 information using both old DRG, and new MS-DRG to an FY07 baseline
- If we had used MS-DRGs, all Services would have seen a net increase

RWP vs MS-DRG RWP (MS-DRG Accepted last meeting)						Service
	RWP Diff	RWP Value Diff	MS-RWP Diff	MS-RWP Value Diff		Net Difference
Army	253	$ 7,585,554	1,142	$ 18,391,215	$	10,805,661
Navy	(3,799)	$ (39,720,559)	(2,952)	$ (31,785,796)	$	7,934,763
Air Force	(772)	$ (5,356,616)	(157)	$ 1,763,988	$	7,120,604

RVU comparison

- Old Method
  - Uses Work RVU for all payments
    - Work RVU only represents provider portion
  - Payments based on Product Lines
    - Defined by MEPRS codes
    - Significant variation in rates ($38/RVU to $330/RVU)
    - Rates based on Allowed Amount from Purchased Care claims divided by Work RVUs
- New Total RVU method
  - Uses both Work and Practice RVUs for payments
    - Practice RVU represents the cost of the staff/office/equipment
  - Provides appropriate credit for equipment intensive procedures
  - Allows for a Standard Rate per RVU
    - Can use same rate as Purchase Care
  - Used with Ambulatory Payment Classification (APCs)
    - Facility charges now available for ER and Same Day Surgery
    - Consistent with TRICARE change for CY09

Geographic Practice Cost Index (GPCI)

- Based on Medicare locality Adjustments
- Different rates for Work and Non-Facility Practice
  - Work
    - Generally 1.0 +, max 1.5 for Alaska
  - Non-Facility Practice
    - Range 0.803 (part of Missouri) to 1.342 (part of California)
- Payment Amount
  - Multiply the RVU for each component times the GPCI for that component

Valuing MHS Workload
Fee for Service Rates (FY10)

- Value per MS-RWP - $9,107 (MEPRS A codes)
  - Average amount allowed
    - Including institutional and professional fees
    - Excluding MH/SA
    - Adjusted for local Wage index and Indirect Medical Education Adjustment (IME)
- Value per Mental Health Bed Day - $769 (MEPRS A codes)
  - Average amount allowed
    - Including institutional and professional fees
    - Adjusted for local Wage index and Indirect Medical Education Adjustment (IME)
- Value per RVU - $36 (MEPRS B codes)
  - Standard Rate – like TMAC/CMS
    - Excluding Ancillary, Home Health, Facility Charges (except ER/SDS)
    - Adjusted for local geographic price index both Work and Practice
- Value per APC - $66 (MEPRS B codes ER/SDS)
  - Standard Rate

Two Rebaselining Issues

- Rebaselining for current performance
- Adjusting PPS targets for programmatic adjustments

Rebaselining current performance

- Move from FY07 to FY09 baseline
- Recognize current performance in programmed budget
- This accounts for system changes in past couple of years
- Adjust outyear targets to current performance

Adjusting PPS targets for programmatic adjustments

- Dollars have been added/subtracted from service budgets based on projected changes in health care requirements resulting from line endstrength changes
- PPS baselines need to be adjusted to reflect the anticipated and already budgeted for change in workload
- Service Agreements for production improvements, instead of prior POM adjustments

Moving from budget to PPS workload

- Adjust target based on dollar budget adjustment
  - 807700 O&M plus MILPERS adjustments
  - Must take into account that PPS is not complete
- Apply percentage ratio
  - Program was adjusted based on MEPRS based full cost and claims of providing care to AD and ADFM
  - Use total non-pharmacy MEPRS cost as denominator and PPS value as numerator

POM and Target Impacts including Programmatic with Lag

	POM Adjustment in Millions			
	Army	Navy	AF	
FY03/07 Net Workload Change	$ 103	$ (33)	$ (53)	$ 17
Workload Increase Commitment	$ -	$ 33	$ 46	$ 79
FY10 POM Adjustment	$ 103	$ -	$ (7)	$ 96
FY09 Programmattic Adjustment (Already Adjusted in POM)	$ 294	$ 4	$ (63)	$ 236
PPS Earnings to MEPRS A/B less Rx ratio	81%	72%	60%	
PPS Adjustment for Programmatic Changes FY09	238	3	(38)	$ 204
Adjusted FY10 Target	$ 238	$ 36	$ 8	$ 283

All dollars are FY08 and must be inflated for FY10 execution

FY 2010 PPS Budget Adjustment

- Military Personnel
  - PPS value includes work produced with military personnel
  - However, MilPers is not in the DHP in year of execution

O&M Factor

	FY 10
Army	69%
Navy	52%
AF	35%
Total	55%

- Adjustment =

  O&M Adjustment *

  (Difference between Most Recent 12 Months Value and FY09 Workload Valued at FY2010 Rates)

- Note: Changed Baseline Year from 2007 to 2009

FY09 Mid Year Summary

	RVUs			RWPs			Mental Health Days		
	FY07	Rolling 12	FY08 Plan	FY07	Rolling 12	FY08 Plan	FY07	Rolling 12	FY08 Plan
Army	13,047,453	13,978,791	13,214,457	105,703	106,045	107,543	34,160	37,220	37,139
Navy	7,879,604	8,055,961	8,067,810	57,955	55,026	59,085	19,437	19,928	19,505
Air Force	6,816,821	6,669,076	6,985,869	34,432	33,187	33,169	4,436	4,974	4,373
MHS	27,743,878	28,703,827	28,268,136	198,090	194,258	199,797	58,033	62,122	61,016

PPS Earnings					
FY07		Rolling 12		FY08 Plan	
2,327,896,326		2,434,046,201		2,374,658,092	
1,358,057,969		1,339,417,994		1,389,131,471	
971,983,881		943,281,083		958,014,070	
4,624,740,086		4,720,622,709		4,721,803,633	

	Millions	
Adjustment	Rolling 12	Plan
Army	72.2	31.8
Navy	(9.1)	15.2
Air Force	(10.6)	(5.2)
Summary	52.4	41.9

FY09 Rates		FY07 and FY09 Plan Earnings are color coded with Green representing Rolling 12 >= 07/plan, yellow within 2% below, and Red >2% below.			
Apr Report		Rolling 12 month is current through 4th month of FY09 for inpatient, and 6th month of FY09 for outpatient			

FY05 (Millions $)

Adjusment	Plan	Mid Year Total
Army	30.6	8.4
Navy	2.2	4.1
Air Force	(2.5)	(4.4)
Total	30.3	8.1

FY06 (Millions $)

Adjustment	Plan	Mid Year
Army	15.4	2.5
Navy	17.3	2.9
Air Force	(16.4)	(20.0)
Total	16.3	(20.4)

FY07 (Millions $)

	Adjustment in Millions
Army	29.2
Navy	(17.1)
Air Force	(20.9)
Total	(8.8)

FY08 (Millions $)

	Millions	
Adjustment	Rolling 12	Plan
Army	20.1	(36.3)
Navy	(9.4)	40.2
Air Force	(6.2)	(57.6)
Summary	4.5	(53.7)

The Future Prospective Payment System

Dr Robert Opsut

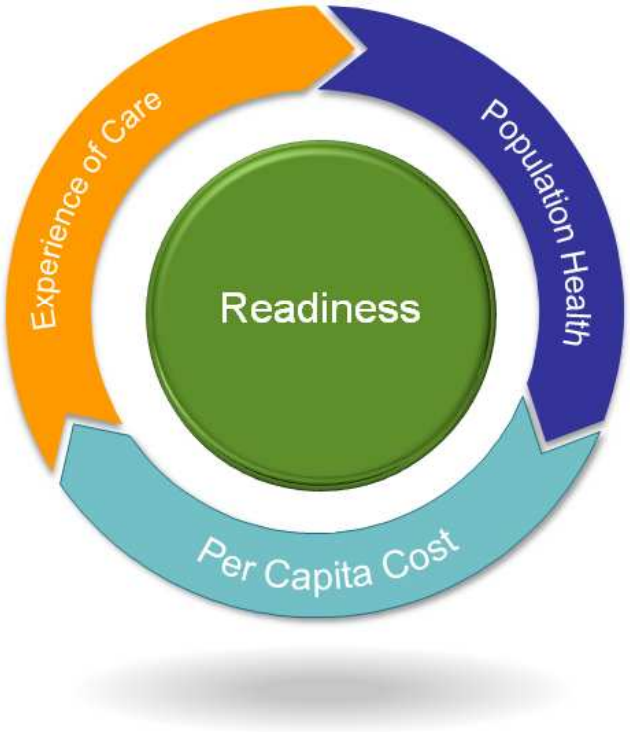
Performance Planning Integrated Project Team

- The Joint Health Operations Council (JHOC) chartered a Performance Planning Integrated Project Team (IPT)
  - Create a revised incentive structure and planning approach aligned with the Quadruple Aim
  - The approach encompasses the total beneficiary population
    - Direct and Purchased
    - Prime, Standard
  - Piloted at six sites in 2010.

Recap – The Quadruple Aim

Readiness

Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.



Population Health

Improving the health of a population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience.

Experience of Care

Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.

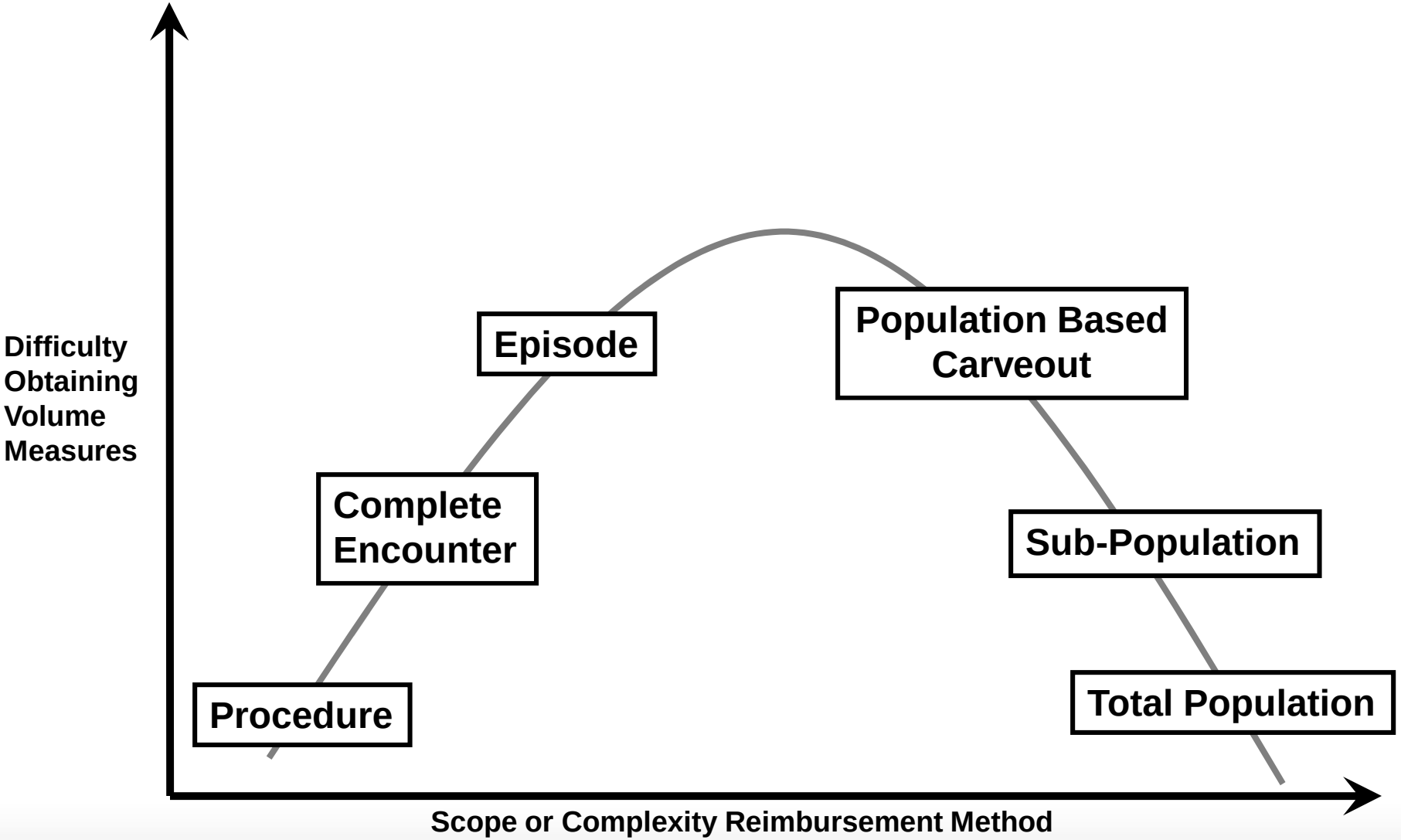
Per Capita Cost

Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

Incorporating the Quadruple Aim in PPS

- For PPS, incorporating the Quadruple Aim involves two changes:
  - Consider changes in the way we measure health care that will incentivize lower per capita costs
  - Consider adjustments based on performance in experience of care and population health
  - Incorporate measures for readiness

Reimbursement Approaches



Parameters

- Boundaries
  - What's in, what's out
- Risk Adjustment
  - Weighting based on expected differences
- Rate
  - Prospective Payment
- Catastrophic Cases
  - Treatment of outliers
- Quality
  - Rewards for experience of care and population health

Strawman

	Funding Approaches	Boundaries	Risk Adjustment	Rate	Catastrophic Cases	Possible Quality Adjustment
1	Readiness	MENBA Activities	None	FFS	None	Indeterminate IMR
2	Wellness	Beneficiary Behavior Activites	None	FFS	None	Healthy behavior measures
3	Prevention	Prevention activities such as mammographies	None	FFS based on RVUs	None	HEDIS
4	Primary Care	Excluding prevention activities and specific populations	None	FFS based on RVUs	None	Access, Sat, ER use, continuity, etc
5	Operating as a PCMH	Management of enrolled population	Age/Gender	Management fee	None	PCMH Standards
6	Specific Populations: Chronic Disease	All care for specific population related to disease	Stages of Disease	PC + Condition capitation	>$150 K	HEDIS/ORYX
7	Specific Populations: Acute Conditions	Specific to condition	Condition Specific	Episode Payment	>$25 K	Episode specific Outcomes
8	Other specialty	Excluding any care in 2-7	None	FFS	None	
9	Other inpatient	Excluding any care in 2-7	None	FFS	None	ORYX
10	Managing per capita costs	All care to an enrolled population	None	None	None	PMPM

Possible MTF Value Structure for Pilot

MTF Value =

+ FFS Rate X # Dental exams and PHAs + IMR P4P

+ FFS Rate X # of preventive services + HEDIS P4P

+ FFS rate X primary care RVUs + Sat/Access/Continuity/HEDIS P4P

+ Management fee (Based on PCMH Standards) X # of enrollees

+ FFS rate X other ambulatory RVUs/APCs

+ FFS rate X other inpatient RWPs/Beddays + ORYX P4P

± Adjustment for performance on Per Capita Costs

Paying for Readiness-Type Costs

Valuing of Mission-Essential Non-Benefit Activities

LTC Sharon Pacchiana, FNP, FACHE

Outline

- Explain Mission-Essential Non-Benefit Activities analysis
- Goals of MENBA
- Activities to-date
- Model and approach
- Status and next steps
- Issues TBD

Mission-Essential Non-Benefit Activities Analysis

- MENBA
  - All those activities done in the MHS which are not tied directly to the health care benefit [i.e. reimbursed under the Prospective Payment System (PPS)]. *EX: Hearing conservation, disability processing, annual readiness training, sexual harassment training, support for ceremonies, etc*
  - Assign a relative value to work such that the value can be multiplied against $$ figure for reimbursement (similar to PPS)

Goals

Overarching Goal: Reflect value-add of staffs' work

1st Stage goal

- Account for what MHS produces

2st Stage goal

- Fund prospectively based on the average value
- Shift funds as workload increases or decreases

3rd Stage goal

- Assess "should we" be doing these; Better way?

Activities to date

2006, 2007

Input from MTFs on their mission essential non-benefit activities

Over 2,800 activities

2,188 Activities

127 Activity Groups

7 Categories

Military Unique Training

Occupational Health Public Health

Readiness Plans, Ops & Deployment

Military Unique Clinical

Military Unique Non- Clinical Activity

GME & GDE

Health Promotion & Wellness

Activities to date

2008, 2009

Military Unique Training

Readiness Plans, Ops & Deployment

Military Unique Clinical

Military Unique Non- Clinical Activity

GME & GDE

Health Promotion & Wellness

Occupational Health Public Health

- ***Patient Movement = a Process***
- ***Medical Evaluation Boards = a System***
- ***Health Education Classes – Episodic Event***
- ***Hearing Conservation = a Program***

4 Activity Groups Selected for Study

- Team visited 14 sites (Army-5; Navy-3; Air Force-6), gathered data and developed model
- Worked with Service SMEs

Model: Methodology Overview

The MENBA team utilized a 5 step output valuation approach to create an RBRVS for each activity group

Step 1: Identify All Activities and Group Into Outputs	• **Ensures all activities within an activity group are identified, then groups them into what will be valued (outputs) .**
Step 2: Define Outputs & Levels	• **Defines the outputs and identifies metrics to measure volume** • **Identifies varying cost drivers that determines the levels of outputs**
Step 3: Determine Output Cost	• **Perform activity based costing (ABC) on MENBA sub-activities and processes that make up the output**
Step 4: Assign Work Intensisty Factor (Non-Cost)	• **Assign a subjective weighting based on the output's level of complexity, judgment and risk**
Step 5: Calculate RBRVS	• **Calculate the RBRVS for each activity group by combining Cost and Non-Cost Factors**

Model: Step 1 - Identify All Activities and Group Into Outputs

Step 1 groups activities from the original list and expands it as appropriate with input from site visits, then groups like activities into outputs. Each output will receive it's own RBRVS value. Thus as with the current PPS system, the volume of each with its RBRVS value would be recorded and reported

Ex: Hearing Conservation

Original MENBA	Outputs
Track employees with Significant or Permanent Threshold Shifts (STS, PTS)	Audiologist Assessments
Follow up with employees with Significant or Permanent Threshold Shifts (STS, PTS)	
Confer with audiologist at DoD Hearing Conservation Diagnostic Center (HCDC) for patient referral	
Provide testing and recommendations on disposition of active duty member / worker with Hearing Loss	
Provide individual counseling for active duty members / workers with noise induced hearing loss	
Conduct training classes on effects of noise	Education & Training Course
Provide training to Medics on hearing protective devices (HPD) fitting and inspection	
Post signs at range on proper hearing protective devices (HPD) use	Operational Assessment & Evaluation - Site Specific
Inspect noise hazardous areas for proper hearing protective devices (HPD)	
Review accident reports of hearing loss from noise exposure and provide feedback to the commander	Civilian Workers Compensation Claim Report
Fit and provide hearing protection	Routine Hearing Test
Conduct audiometric monitoring and follow-up testing	
Conduct trend analysis for hearing conservation	Hearing Conservation Program - Admin Requirements As there were no identifiable outputs, the cost s/resources of administration activities was allocated to other outputs
Conduct hearing conservation program	
Purchase earplug and case supply for installation	
Provide commander report on installation hearing conservation program	
Test new hearing protective devices (HPD) for use	
Installation OPR for Memorandum of Instruction (MOI) detaining Hearing Conservation Program	
Conduct noise surveys of units and combat vehicles	IH Noise Survey This activity/ output was aligned to another MENBA (Industrial Hygiene)

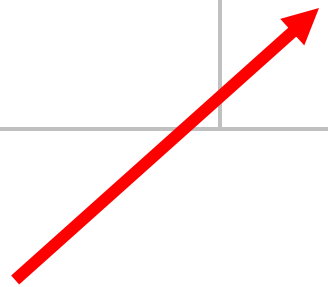
Model: Step 2 - Define Outputs & Levels

Step 2 subdivides each output into intensity levels as appropriate and defines them specifically

#	Output	Definition
1	Routine Hearing Test	
2	Audiologist Assessment	
3	Audiologist External Records Review	
4	Audiologist Hearing Protection Custom Fit	
5	Education & Training Course - Certification Course	EXAMPLE DEFINITIONS
6	Education & Training Course - 1-2 Hours	All activities and documentation associated with providing a two hour or less lecture, classroom or one-on-one training. This includes but is not limited to curriculum development, material preparation and course instruction. This output is limited to the instructor only.
7	Education & Training Course - Over 2 Hours (HC Officers / Medics Training)	All activities and documentation associated with providing a half-day training course for unit Hearing Conservation Officers / Medics. This includes but is not limited to curriculum development, material preparation and course instruction. This course includes training on but not limited to basic ear health, how to identify disease, how to fit HPD and how to educate their units on the importance of noise safety. This output is limited to the instructor only.
8	Operational Mission Consultation (Operational Hearing Services)	All activities and documentation associated with an audiological assessment of operational noise hazardous areas. Activities include but are not limited to consultation of tactical communication device use, providing written information about devices assessed for future purchases, and training on use of integrated communication devices in an operational setting.
9	Operational Site Assessments – Unit Consultation up to 2 Hours	
10	Operational Site Assessments – Unit Consultation over 2 hours	
11	Clinic Review	
12	Civilian Workers Compensation Claim Report	

Model: Step 2 - Define Outputs and Levels

Activity Group	Number of Activities	Output Categories	Unique Outputs
Disability Evaluation System	18	10	20
Hearing Conservation Program	***24***	***7***	***12***
Patient Movement	18	13	75
Health Education Classes	43	6	18
Totals	103	36	125
Total MENBA activities	**2,188**		



Model: Step 3 - Determine Output Cost

Step 3 establishes the average cost of each unique output

Below are cost calculations for the Hearing Conservation outputs

Output	Time-to-Task Per Output (minutes)	Labor cost per Output	Equipment & Supply Cost Per Output	Supervisory Cost Per Output	Total Cost Per Output
Routine Hearing Test	32.5	$ 15.90	$ 0.89	$ 2.16	$ 18.95
Audiologist Assessment	57.5	$ 70.19	$ 3.29	$ 3.82	$ 77.30

Labor Costs (Time * Labor Cost per Output)
+ Equipment & Supply Cost Per Output
+ Supervisory Cost Per Output
= Total Cost Per Output

Model: Step 4 – Assign Work Intensity Factor

Step 4 establishes the non-cost factor based on the intensity of the output (technical skill and physical effort, mental effort and judgment, risk of failure, complexity, total work)

- ***Previous approach***
  - A questionnaire was submitted to activity SME, consultants, and POC's asking for their subjective valuation in the assessment of the outputs
  - Outliers were removed and Service consultants and activity group SMEs were engaged in the final validation of the overall intensity assignments
  - Issues occurred with small sample, mixed target population
- ***Proposed approach***
  - Revise methodology
    - Target survey sample tool to only relevant employees (those directly responsible for the activity)
    - Expand sample sites

Model: Step 5 – Calculate RBRVS

Step 5 develops the Resource-Based Relative Value Scale (RBRVS) which incorporates the work intensity into the activity based costing of each output

- ***Approach***
  - Split cost into a work component (labor cost of relevant employees) and a practice component (support labor plus non-labor costs)
  - Apply intensity factor to the work component to derive an adjusted work component
  - Total RBRVS will be intensity adjusted work component plus the practice component

- ***Clinical Interface – determining a method to align scale to the clinical RBRVS (PPS)***
  - Reason: for comparability/alignment of outputs
    - Across all MENBA groups
    - To clinical outputs (RVU)

Status

2010 thus far

- Briefed Deputy Surgeons General

  Approved products and continuing with model/activity group development

- Currently in-between contractors

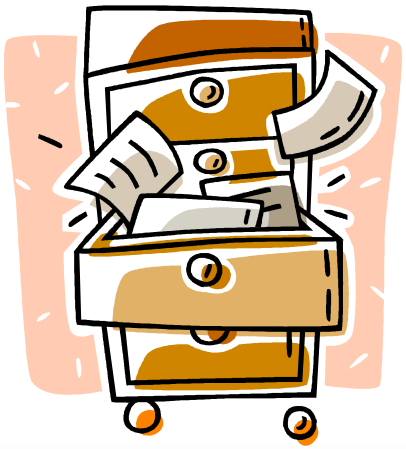
- While Waiting: Development at this time concentrated on the Disability Evaluation System (DES)
  - Currently working with NNMC Bethesda to collect data and refine model
  - Working with JTF CAPMED to expand to other NCR sites

Next Steps

- Expand DES to other NCA sites
- Develop model further
  - Refine model further to account for intensity factors
  - Determine methodology to align to the clinical RBRVS
- Collect additional data at a variety of MTFs for the 4 initial activity groups
- Analyze additional activity groups

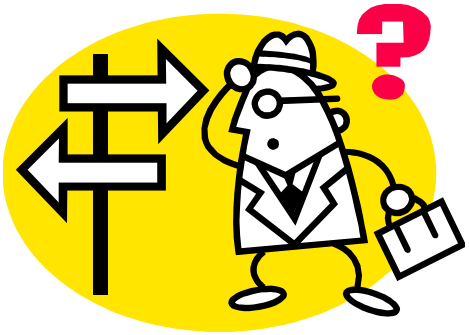
Issues TBD

- Workload capture and reporting
  - Volume (for 4 activity groups studied, requires capturing data on volume for 125 unique outputs)
  - Systems for capture *(in order of possible development time)*
    - Current system if exists and meets requirements or can be easily modified
    - Manual reports
    - SADR
    - WWR (or its successor)
    - New system



Issues TBD

- Application
  - How to integrate with current system
    - Use solely for analysis?
    - Use in the planning, programming, budgeting system?
  - Degree
    - Incremental starting with resourcing through PPS a few activity groups at a time?
    - Wait for all MENBA groups to be developed?



Questions

Back Up Material

Industry Standard Workload

- Inpatient/Outpatient vs. Institutional/Professional
- Industry Based Workload Alignment (IBWA)
  - Rounds capture 2yrs old (appx 80% complete)
  - Full Inpatient professional workload capture began last year
  - Enhanced SADR (Standard Provider ID plus Modifiers)
  - Would allow PPS value to follow more closely TMAC
  - Would allow credit for professional work done away from facility
    - External Resource Sharing
    - Circuit Riders
    - Joint Facilities
- Full RVU vice Simple Work RVU

IME Factors

DMIS	Name	FY02	FY03	FY04	FY05	FY06	FY07	FY09	FY10
0014	DAVID GRANT	1.4141	1.3765	1.5737	**1.5996**	**1.6313**	**1.5676**	**1.3485**	**1.2930**
0024	PENDLETON	1.2895	1.1860	1.1681	**1.1848**	**1.1828**	**1.1739**	**1.1304**	**1.1476**
0029	SAN DIEGO	1.6415	1.5067	1.5067	**1.5173**	**1.4929**	**1.4588**	**1.4554**	**1.5370**
0037	WALTER REED	1.5849	1.5175	1.5265	**1.5523**	**1.5368**	**1.5824**	**1.5061**	**1.6961**
0038	PENSACOLA	1.2692	1.2269	1.2269	**1.2302**	**1.1938**	**1.1713**	**1.2092**	**1.2045**
0039	JACKSONVILLE	1.3484	1.2954	1.2911	**1.2944**	**1.2866**	**1.2669**	**1.2690**	**1.2086**
0042	EGLIN	1.2544	1.2801	1.3120	**1.3202**	**1.2622**	**1.1859**	**1.1928**	**1.2346**
0047	EISENHOWER	1.2772	1.2216	1.2208	**1.2318**	**1.2096**	**1.2352**	**1.2031**	**1.2249**
0048	MARTIN	1.2230	1.1733	1.1462	**1.1547**	**1.1477**	**1.1422**	**1.1408**	**1.1498**
0052	TRIPLER	1.3792	1.3249	1.3319	**1.3482**	**1.3987**	**1.3813**	**1.4400**	**1.4859**
0055	SCOTT	1.3377	1.2983	1.3119	**1.3034**	**1.2689**	**1.2554**	**1.0000**	**1.0000**
0066	MALCOLM GROW	1.3646	1.3306	1.3898	**1.4492**	**1.4366**	**1.4199**	**1.3663**	**1.2949**
0067	BETHESDA	1.6914	1.5430	1.5413	**1.4705**	**1.4139**	**1.3984**	**1.3493**	**1.3882**
0073	KEESLER	1.4844	1.3613	1.2533	**1.4352**	**1.4806**	**1.0000**	**1.0737**	**1.0737**
0078	EHRLING BERGQUIST	1.3313	1.3286	1.3961	**1.5929**	**1.3220**	**1.0000**	**1.0000**	**1.0000**
0086	KELLER	1.0114	1.0309	1.0417	**1.0398**	**1.0394**	**1.0372**	**1.0379**	**1.0394**
0089	WOMACK	1.1396	1.1176	1.1254	**1.1259**	**1.1187**	**1.1460**	**1.1425**	**1.1471**
0091	LEJEUNE	1.0000	1.0000	1.0000	**1.0621**	**1.0604**	**1.0976**	**1.0637**	**1.0548**
0095	WRIGHT-PATTERSON	1.6438	1.6523	1.7406	**1.6789**	**1.6153**	**1.5976**	**1.3764**	**1.4453**
0108	WILLIAM BEAUMONT	1.2425	1.1995	1.1971	**1.2033**	**1.2267**	**1.2041**	**1.2129**	**1.2461**
0109	BROOKE	1.5289	1.4459	1.4553	**1.4776**	**1.4565**	**1.4353**	**1.4474**	**1.5329**
0110	DARNALL	1.1182	1.0996	1.0996	**1.1035**	**1.0977**	**1.0914**	**1.0987**	**1.0932**
0117	WILFORD HALL	1.5818	1.4904	1.6006	**1.6300**	**1.5887**	**1.5694**	**1.5887**	**1.6467**
0123	DEWITT	1.2275	1.1883	1.1883	**1.1942**	**1.1920**	**1.2071**	**1.1974**	**1.2011**
0124	PORTSMOUTH	1.3389	1.3066	1.3066	**1.3216**	**1.3126**	**1.3005**	**1.2684**	**1.3324**
0125	MADIGAN	1.6389	1.5363	1.5630	**1.5438**	**1.4788**	**1.4499**	**1.4534**	**1.4947**
0126	BREMERTON	1.1716	1.1701	1.1817	**1.1902**	**1.2009**	**1.1977**	**1.1858**	**1.1783**

Value of 1.0 is used if there is no IME to zero out calculation in reconciliation.

Total RVUs/APC

- Issue: Should PPS use Total RVUs (Excluding Nurses) and APCs for ER/SDS to value outpatient workload?

- Pros:
  - More accurate representation of intensity of care
  - Consistency with TRICARE for professional and facility payments
  - TRICARE rate can be applied directly without need for averaging of claims
  - Reduces incentive to improperly code care that is part of another encounter
  - Removes artificial product line rate variations
  - Expands facility payments to Same Day Surgeries
- Cons:
  - Business Plans used Work RVUs only
  - Some Adjustments in Service level PPS earnings

Army Programmatic Change Impact

INCREASES TO ARMY O&M - FY 08-13 End Strength Increases and FY 09-13 Ground Forces Augmentation

		FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
FY 08-13 ENDSTRENGTH ADJUSTMENT							
In-House Care							
0807700		5,587	13,302	18,987	24,316	28,285	30,433
FY 09-13 GROUND FORCES AUGMENTATION							
In-House Care							
0807700	MEDCENs, Hospitals & Clinics (CONUS)	16,680	239,225	275,254	329,849	372,742	398,252
	PPS Adjustment (Full Value)	**22,267**	**252,527**	**294,241**	**354,165**	**401,027**	**428,685**
	PPS Adjustment(Adj Value 81%)		204,547	238,335	286,874	324,832	347,235

Navy Programmatic Change Impact

			FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
In-House Care								
0807700	MEDCENs, Hospitals & Clinics (CONUS)		-18,608	-34,336	-39,777	-42,686	-44,204	-47,396
0807900	MEDCENs, Hospitals & Clinics (OCONUS)		-12	-36	-64	-100	-172	-277
0807701	Pharmaceuticals, In-House (CONUS)		-14,687	-23,455	-26,780	-29,763	-32,799	-37,138
0807901	Pharmaceuticals, In-House (OCONUS)		-6	-21	-39	-64	-116	-196
0807715	Dental Care Activities - CONUS		-9,489	-6,194	-6,684	-7,235	-7,782	-8,415
0807915	Dental Care Activities - OCONUS		-2	-8	-14	-22	-38	-61
	Subtotal In-House Care		-42,804	-64,050	-73,358	-79,870	-85,111	-93,483
Base Operations/Communications								
0806276	Facilities Restoration and Modernization - CONUS		-1,357	-2,081	-2,218	-2,365	-2,521	-2,688
0806376	Facilities Restoration and Modernization - OCONUS		0	0	0	0	0	0
0806278	Facilites Sustainment - CONUS Health Care		-3,391	-5,203	-5,546	-5,912	-6,303	-6,721
0806378	Facilites Sustainment - OCONUS Health Care		0	0	0	0	0	0
0807779	Facilities Operations - Health Care (CONUS)		0	0	0	0	0	0
0807979	Facilities Operations - Health Care (OCONUS)		0	0	0	0	0	0
0807795	Base Communications - CONUS		0	0	0	0	0	0
0807995	Base Communications - OCONUS		0	0	0	0	0	0
0807796	Base Operations - CONUS		0	0	0	0	0	0
0807996	Base Operations - OCONUS		0	0	0	0	0	0
0807753	Environmental Conservation		0	0	0	0	0	0
0807754	Pollution Prevention		0	0	0	0	0	0
0807756	Environmental Compliance		0	0	0	0	0	0
0807790	Visual Information Systems		0	0	0	0	0	0
0808093	Demolition		0	0	0	0	0	0
	Subtotal Base Ops/Comm		-4,748	-7,284	-7,764	-8,277	-8,824	-9,409
TOTAL		Navy O&M Total	-47,552	-71,334	-81,122	-88,147	-93,935	-102,892
		Navy MILPERS	-41,457	-62,313	-70,991	-76,955	-80,649	-86,443
		GRAND TOTAL	-89,009	-133,647	-152,113	-165,102	-174,584	-189,335
		PPS Adjustment (ES Decrease)	-60,065	-96,649	-110,768	-119,641	-124,853	-133,839
		GFA Added	12,347	102,929	114,798	144,283	161,930	171,681
		PPS Adjustment (Full Value)	**-47,718**	**6,280**	**4,030**	**24,642**	**37,077**	**37,842**
		PPS Adjustment(Adj Value 72%)		4,522	2,902	17,742	26,695	27,246

Air Force Programmatic Change Impact

Reductions applied to Air Force based on Line End Strength Reductions ($K)

			FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
In-House Care								
0807700	MEDCENs, Hospitals & Clinics (CONUS)		-2,310	-7,707	-11,393	-1,692	-2,420	-3,192
0807900	MEDCENs, Hospitals & Clinics (OCONUS)		-7	-35	-81	-135	-194	-259
0807701	Pharmaceuticals, In-House (CONUS)		-32,942	-47,606	-63,143	-83,748	-93,157	-93,707
0807901	Pharmaceuticals, In-House (OCONUS)		-3	-20	-49	-87	-131	-184
0807715	Dental Care Activities - CONUS		-9	-49	-116	-193	-285	-390
0807915	Dental Care Activities - OCONUS		-1	-8	-18	-30	-43	-57
	Subtotal In-House Care		-35,272	-55,425	-74,800	-85,885	-96,230	-97,789
TOTAL		Air Force TOTAL O&M	-35,272	-55,425	-74,800	-85,885	-96,230	-97,789
		MILPERS	-25,819	-39,845	-51,402	-52,163	-52,735	-58,494
		GRAND TOTAL	-61,091	-95,270	-126,202	-138,048	-148,965	-156,283
		PPS ADJUSTMENT (Full)	**-28,129**	**-47,552**	**-62,795**	**-53,855**	**-55,155**	**-61,686**
		PPS Adjustment(Adj Value 60%)		-28,531	-37,677	-32,313	-33,093	-37,012

Issues to Consider

- Incorporate Inpatient Professional Services
  - Professional services should be coded this year
    - UBU has information in guidance
    - Initial focus External partnerships
      - PPS Payment begins FY2008
  - Eventually need to expand to all inpatient care
    - For rounds only Approximately 80% complete (20% lost value)
    - Began 1 Oct 2002
    - Other Professional much less complete and more valuable
- Accurate coding
  - Ensure proper coding for inpatient services are captured in MEPRS A codes
  - Need to ensure coding matches documentation
  - Eventually audit adjustments to claims
  - All MTFs need to Ensure Timely data submission
- Non Provider specialty codes (Generic Clinics)
  - Last year workload accepted was FY06
  - FY07/08 no workload credit
- Treatment of Enrollees
  - Quality payments will rely on accurate identification of Enrollees
  - Documentation of treatment for Preventive Services

Mission Essential Non-Benefit Activities

slide 1 of 2

Category	High Level MENBA	Detail Level
Military Unique Clinical Activity	**34 Activity Groups**	**612 subactivities**
	Patient Movement	
	Aeromedical Staging Facility Operations	
	Military Blood Program	
	Boards	
	Support Services for Special Populations	
	Case Management	
	Institutional Research Program	
	Operational Flight Medicine	
	Hyperbaric Medicine	
	HIV Program	
	Drug Screening Program	
	Military Specific Medical Management	
	Child Protection Services Through AFCCP	
	Sexual Abuse Recovery Center (SARC)	
	Family Advocacy Program	
	Mental Health Services	
	Substance Abuse Prevention Services	
	Military Specific Nursing Administration	
	Military Specific Pharmacy Services	
	Profile Program	
	PRP Program	
	Credentials Management	
	Assignment Screening	
	Telemedicine	
	Volunteer Program	
	Predeployment Medical	
	Support During Deployment	
	Post Deployment Medical Screening	
	IMR	
	Periodic Health Assessment (PHA) Program for Active Duty	
	Optometry Services for AD members	
	Eyewear for Vision Correction	
	Eyewear for Protection	
	Refractive Surgery Program	

Category	High Level MENBA	Detail Level
Health Promotion & Wellness	**11 Activity Groups**	**111 subactivities**
	Health Promotion Program Administration	
	Health Education Classes	
	Web Based Programs, Internet Outreach	
	Physical Activity Program - all beneficiaries	
	Physical Fitness Program - Active Duty	
	Tobacco Cessation Program	
	Health Promotion Marketing	
	Health Promotion Articles	
	Health Fairs	
	Community Assessment	
	Educational Development Intervention Service (EDIS)	

Total Categories: 7

Total Activity Groups: 127

Total Sub-activates: 2188

Category	High Level MENBA	Detail Level
Occupational Health_Public Health Activity	**26 Activity Groups**	**396 subactivities**
	Support to Family Services	
	Oversight Guidance	
	Health Education and Training for Installation	
	First Aid & Life Support for Installation	
	Facility Inspections	
	Housing Inspections	
	Industrial Hygiene Inspections	
	Consultation for Installation	
	HazMat Monitoring	
	HazMat Spill Expertise	
	Hearing Conservation Program	
	Radiation Safety Program	
	Safety Protection Program	
	Environmental Exposure Surveillance Program	
	Occupational Health Clinical Services	
	Drinking Water Surveillance Program	
	Recreation Water Surveillance Program	
	Waste Water Surveillance Program	
	Physiological Training Program	
	Employee Health Surveillance Program	
	Exposed Patient Surveillance Program	
	Influenza Surveillance Program	
	Injury and Communicable Disease Surveillance Program	
	Installation Animal Program	
	Installation Food Surveillance Program	
	Installation Vector Surveillance Program	

Initial List 2007

Mission Essential Non-Benefit Activities

slide 2 of 2

Category	High Level MENBA	Detail Level
Military Unique NonClinical Activity	**18 Activity Groups**	**328 subactivities**
	Additional Duty Program	
	Military Agency Support	
	Career Counseling	
	Military Ceremonies	
	Commander Support	
	County and State Meetings	
	Decedent Affairs Program	
	Nutrition Consultation	
	Expert Opinion	
	Biomedical Equipment Repair	
	Military Specific Information Management	
	Information Management Security	
	Telemedicine Support	
	MOU/MOA program	
	Military Specific Patient Administration	
	Military Specific Resource Management	
	GWOT Resource Accounting	
	Military Vehicle Program	

Category	High Level MENBA	Detail Level
Readiness Plans, Operations & Deployment Activity	**13 Activity Groups**	**206 subactivities**
	Readiness Administration	
	Manpower Augmentation	
	Installation/Deployment Support Medical Planning	
	Medical Logistics Support for Installation	
	Secure Communication Capability	
	Exercise Support	
	Civil Support	
	WRM	
	Planning	
	Medical Unit Deployment	
	NDMS Planning and Exercises	
	Contingency Planning	
	Security Clearance Program	

Category	High Level MENBA	Detail Level
GME_GDE Activity	**4 Activity Groups**	**115 subactivities**
	GME_GDE Program Administration	
	GME_GDE Program Oversight	
	GME_GDE Students	
	Training Opportunities for Medical Students	

Category	High Level MENBA	Detail Level
Military Unique Training Activity	**21 Activity Groups**	**420 subactivities**
	TRG Program Administration	
	Awareness TRG	
	Supervision for Civilian Students	
	Competency Verification Program	
	TRG Conferences	
	Continuing Education Programs	
	EMT Program	
	First Term Enlisted TRG	
	Information Management Courses	
	Inprocessing Program	
	Internet Based Training Program	
	Job Specific Training	
	Leadership TRG	
	Library Administration	
	Life Support TRG	
	OJT Program Support	
	Orientation	
	Phase ll TRG	
	CBRN Readiness TRG	
	Environmental Readiness TRG	
	Job Specific Readiness TRG	